

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8129580			
1. FOR STATE REGISTRAR			1. DECEASED NAME FIRST William NMN MIDDLE Archibald LAST				2a. DATE OF DEATH November 30, 1981		MONTH DAY YEAR		2b. HOUR 4:25PM		
3. SEX Male			4. RACE White		5. DATE OF BIRTH MONTH 6 DAY 12 YEAR 1892			6. AGE (IN YEARS LAST BIRTHDAY) 89		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? America		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.					
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Annes Hospital, Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Power Plant Wkr		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 3 Box 284					
14. FATHER'S NAME FIRST John NMN MIDDLE Archibald LAST			15. MOTHER'S MAIDEN NAME FIRST Mary NMN MIDDLE Hurlock LAST										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 213-22-8477			17. INFORMANT Wm. Kamiski			ADDRESS Seton Villa Wilm. Del. 19809				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4810 Pneumonia 3 days										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hiccups - acute renal failure - septic shock													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Nov. 30 1981, to Nov. 19 1981, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Dr. C. Gottfried Baumann, M.D.			DEGREE 44			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/1/81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. C. Gottfried Baumann, M.D.			22e. ADDRESS Kent & Queen Annes Hospital, Inc.										
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial			23b. DATE 12/5/81		23c. NAME OF CEMETERY OR CREMATORIAL Still Pond Cemetery			23d. LOCATION CITY OR TOWN Still Pond, Md.		COUNTY STATE			
24. FUNERAL DIRECTOR NAME Willis Wells Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR DEC 4 1981			25b. REGISTRAR'S SIGNATURE Frances J. Warthen							



1981 / 030

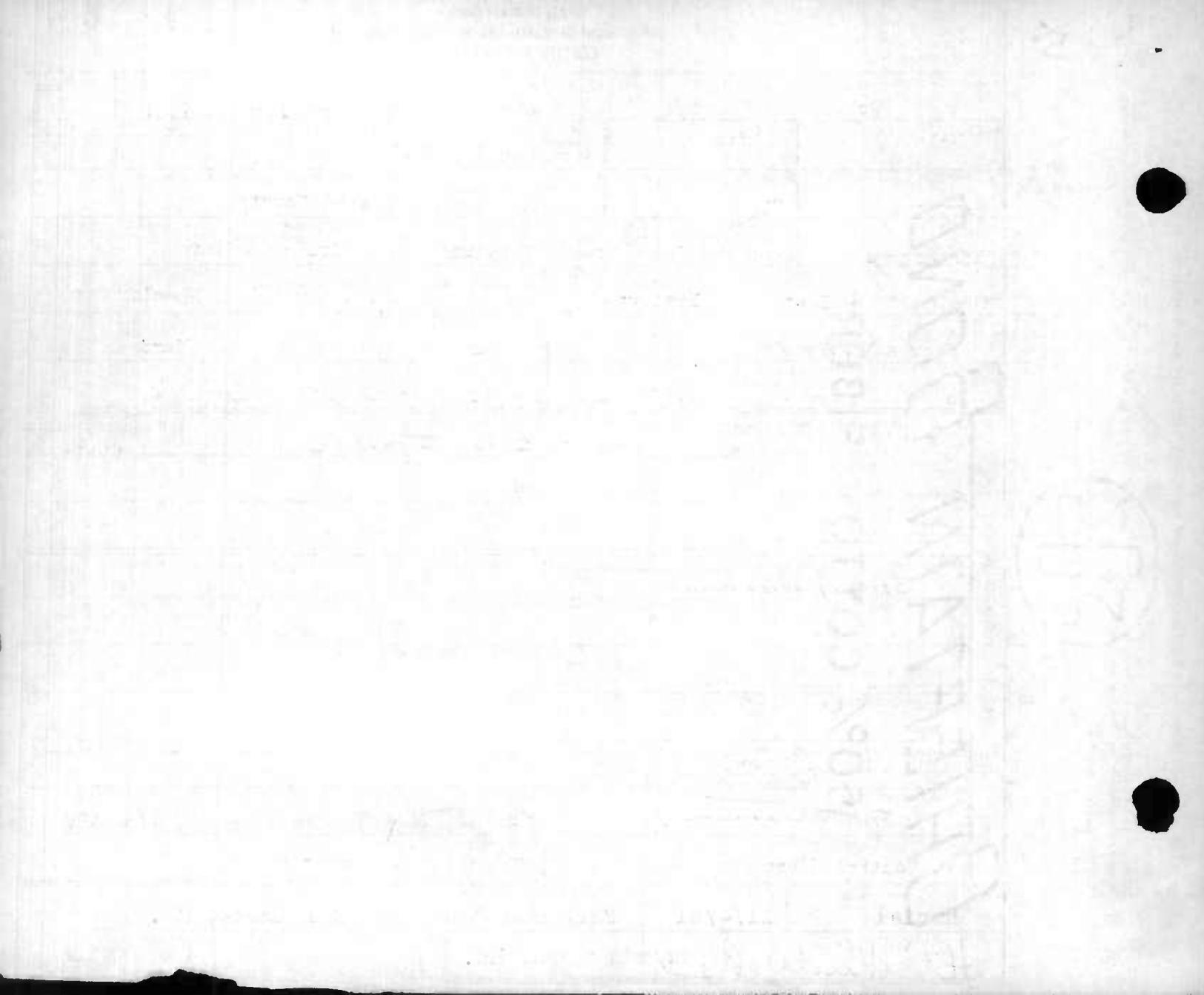
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IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be consulted and/or

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 81 29581	
1. FOR STATE REGISTRAR							
I. DECEASED NAME (TYPE OR PRINT)		FIRST Robert	MIDDLE Patrick	LAST Brooks		2d. DATE OF DEATH MONTH DAY YEAR November 2, 1981	
3. SEX Male		4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR November 17, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 83	7b. HOUR AM 6:25 M	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County		
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Auditor		
13a. STATE Maryland		13b. COUNTY Kent	13c. CITY OR TOWN Betterton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS P.O. Box 141 (3 Wheeler Ave)	
14. FATHER'S NAME FIRST George NMN		MIDDLE Brooks	LAST	15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE Ellen	LAST Finnigen
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. -	16c. INFORMANT Hospital Records, Chestertown, Md.	ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week							
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prob. CVA (c) DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Strep. pneumoniae							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from October 25, 1981, to November 2, 1981, that (I) (we) last saw the deceased alive on November 2, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>C. Gottfried Baumann</i>		DEGREE KGS	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11/2/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Gottfried Baumann		22e. ADDRESS Chestertown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/4/81	23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery	23d. LOCATION CITY OR TOWN Baltimore, Md.	COUNTY	STATE	
24. FUNERAL DIRECTOR NAME <i>Willis Wells</i>		25a. DATE REC'D. BY REGISTRAR NOV 5 1981			25b. REGISTRAR'S SIGNATURE <i>Peter J. Van Winkle</i>		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3 RETAIN PAGE 4 AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REASONAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 29582		
1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>Katherine</b>			MIDDLE <b>BURNETT</b>			LAST			2a. DATE KNOWN OF DEATH ESTI- MATED	2b. MONTH DAY YEAR	2b. HOUR 11-17 19 81 3:00	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 11 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80 yrs.</b>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>Nov 17 1981</b>	2d. MONTH DAY YEAR	2d. HOUR 1:15 1:15
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Kent Co.</b>								
10. CITY OR TOWN OF DEATH <b>Chestertown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (DO NOT INDICATE FACILITY, GIVE STREET ADDRESS) <b>At Home Campus Ave.</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Kent</b>		14. CITY OR TOWN <b>Chestertown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Campus Ave. #200 West</b>						
14. FATHER'S NAME FIRST <b>L. P. McDaris</b>		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST <b>Margaret</b>		MIDDLE			LAST <b>Cordell</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>239 76 7874</b>		17. INFORMANT <b>E. S. Cookerly</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>Arteriosclerotic Cardiovascular Disease</b>		ADDRESS <b>Chestertown, Md.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>Arteriosclerotic Cardiovascular Disease</b>		IMMEDIATE CAUSE (a) <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.		DUE TO, OR AS A CONSEQUENCE OF		(b) DUE TO, OR AS A CONSEQUENCE OF								
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that I am in charge of the remains described above, held on <b>11/19/81</b> . Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <input checked="" type="checkbox"/> Natural death <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE 		EXAMINER'S NAME (TYPE OR PRINT) <b>Robert W. Farr</b>		TITLE (SPECIFY) <b>Deputy</b>		M.D.		MEDICAL EXAMINER			DATE SIGNED <b>11/17/81</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIAL) <b>Burial</b>		23b. DATE <b>11/19/81</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Paul's Cemetery</b>		23d. LOCATION CITY OR TOWN <b>near Chestertown, Md.</b>		COUNTY			STATE			
24. FUNERAL DIRECTOR NAME <b>J. Willis Wells</b>		ADDRESS <b>Chestertown, Md.</b>		25. DATE REC'D. BY REGISTRAR <b>NOV 20 1981</b> REGISTRAR'S SIGNATURE <b>Chances Jan Miller</b>										
BP _____		DHMH - 17 FVR A15 ME (3) 15M 7/76												

1891-1892

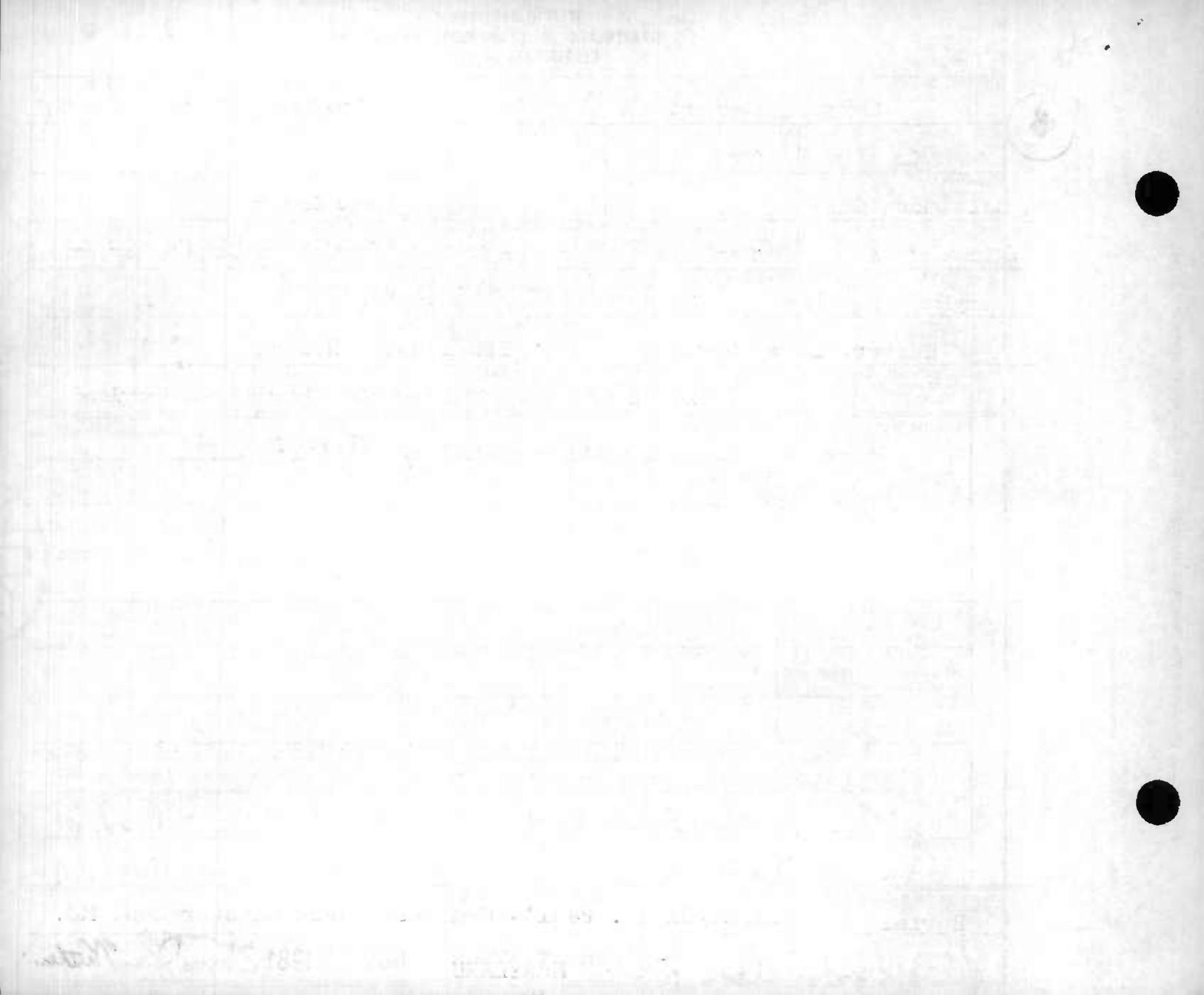
1891-1892

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												81 29583		
												REG. NO.		
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			Leroy Herbert Dowling						November 23, 1981			10:15 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White		December 30, 1925			55			YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Baltimore City		U.S.A.					Kent County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Chestertown		Kent and Queen Anne's Hospital					Service man Stenger Hardware							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Maryland		Kent		Chestertown						Rt. 3				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
Herbert Leroy Dowling		Ethel Rose Heline												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			21620				
no		214 32 0639		Hospital Records- Chestertown, Maryland										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Arrest</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4275 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from November 23, 1981, to November 23, 1981, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE <u>Gene M. Daffern MD</u> DEGREE		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED						
Gene M. Daffern		1114 Dunwoon Rd, Silver Spring, Md.						11/24/81						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Cemetery			23d. LOCATION near Chestertown, Md.							
Burial		11/25/81												
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Willis Wells		CHESTERTOWN MARYLAND			NOV 27 1981			James J. Warner						
BP _____														
DHMH-16 30M 2/80 (VRA 15, 4)														



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												REG. NO.		
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			ANDREW J. FRITZ						Nov. 22, 1981			10 A M		
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
male		white		Nov. 17, 1900			81 YRS			MONTHS	DAYS	HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland		USA					Kent							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NAME OF NOT FOR PROFIT FACILITY, IF APPLICABLE, WITH ADDRESS)		12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY							
Chestertown		Magnolia Hall Nursing Center					Route owner Sunpaper							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE Maryland		13c. CITY OR TOWN Anne		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS RFD # 1 Box 233A							
14 FATHER'S NAME FIRST John		MIDDLE Fritz		15. MOTHER'S MAIDEN NAME FIRST Lena Schick MIDDLE Scheck Schenkx										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. NO 218 32 1091		17. INFORMANT Jackson W. Fritz			ADDRESS Centreville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate &amp; metastasis</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years		
1850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Arteriosclerotic Cardiovascular disease</u>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>August 11, 1980</u> , to <u>11/22/81</u> , that (I) (we) last saw the deceased alive on <u>19, 81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 11/22/81		
22b. SIGNATURE <u>Susan K. Ross M.D.</u>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Susan K. Ross		22e. ADDRESS Chestertown, Md.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) entombment		23b. DATE 11/23/81		23c. NAME OF CEMETERY OR CREMATORIAL Lorraine Cemetery			23d. LOCATION CITY OR TOWN Baltimore, Md.			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME <u>J. Willis Wells</u>		ADDRESS Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR NOV 27 1981			25b. REGISTRAR'S SIGNATURE <u>James Van Wart</u>						

520

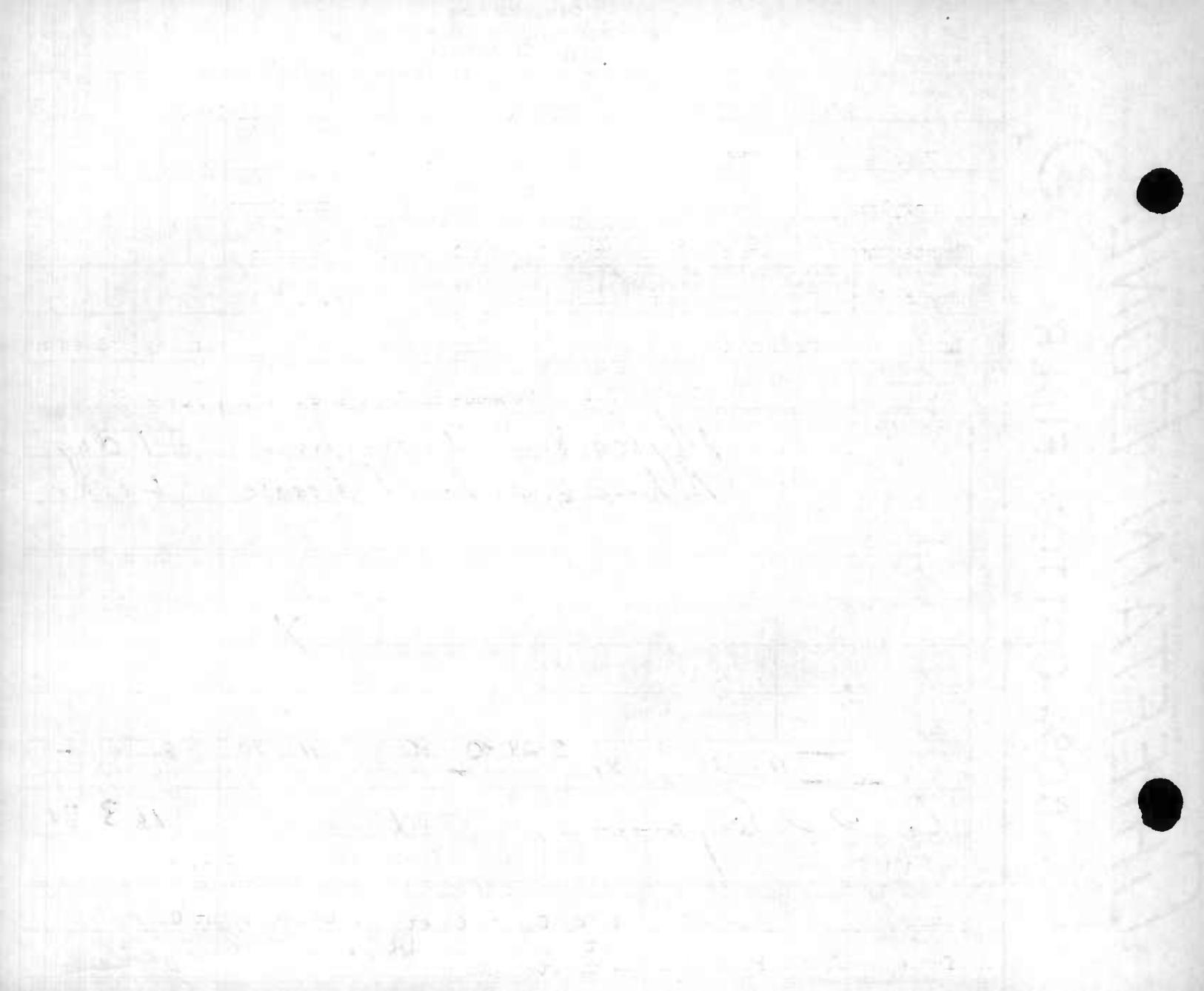


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 8129385			
1 - FOR STATE REGISTRAR			1. DECEASED NAME FIRST ADA MIDDLE OLIVIA LAST HYNSON			2a. DATE OF DEATH MONTH 11-30-81 DAY 11 YEAR 81	2b. HOUR 4:00 PM		
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH 7 DAY 29 YEAR 04	6. AGE (IN YEARS LAST BIRTHDAY) 77	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN. 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? America			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.		
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Annes Hospital, Inc.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Kent		13c. CITY OR TOWN Rock Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS R.R. # 1	
14. FATHER'S NAME FIRST David MIDDLE Crockett LAST Ashley			15. MOTHER'S MAIDEN NAME FIRST Clare MIDDLE NMN LAST Ashley (maiden name)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-74-0391			17. INFORMANT ADDRESS Rebecca Kelley, Rock Hall, Md. 21661		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 day week	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <input type="checkbox"/> attended the deceased from <b>3-24-80</b> , 19 <b>80</b> , to <b>11-30</b> , 19 <b>81</b> , that (I) <input type="checkbox"/> lost saw the deceased alive on <b>11-30</b> , 19 <b>81</b> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> did not <input type="checkbox"/> view the body after death.									
22b. SIGNATURE <b>D. Benjamin</b>		DEGREE				22c. DATE SIGNED <b>12-3-81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Wayne Benjamin</b>		22e. ADDRESS Kent & Queen Annes Hospital, Inc.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-3-81</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Wesley Chapel Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Rock Hall, Kent Co. Md.</b>		COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Helfenbein-Hubbard Funeral Home</b>		ADDRESS <b>Rt#1 Box#66-B Chester, Md.</b>		25a. DATE REC'D BY REGISTRAR <b>DEC 7 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Anna J. Lester</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.				
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR A.M./P.M.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	Nov. 25, 1981							A.M.	
ERNEST LEVERAGE													3 P.M.	
3. SEX <b>Male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
7b. BIRTHPLACE COUNTRY <b>Maryland Queen Anne Co.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		Nov. 21, 1906			75 YRS.		MONTHS DAYS		HOURS MIN			
8. CITY OR TOWN OF DEATH <b>Chestertown</b>		9. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>At Home 409 High St.</b>		10. CITY OR TOWN <b>Chestertown</b>			11. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>T.V. Repair</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>Md.</b>		13b. COUNTY <b>Kent</b>		13c. CITY OR TOWN <b>Chestertown</b>			13d. INSIDE CITY LIMITS? <b>YES</b>		13e. STREET ADDRESS <b>409 High St.</b>					
14. FATHER'S NAME FIRST <b>Carroll F.</b>		MIDDLE <b>Leverage</b>		LAST			15. MOTHER'S MAIDEN NAME FIRST <b>Grave</b>		MIDDLE <b>Meredith</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220 09 1018</b>		16c. PART I. DEATH WAS CAUSED BY <b>4292</b>		17. INFORMANT <b>Delores Leverage</b>		ADDRESS <b>Chestertown, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<b>-Probable Acute congestive heart failure</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic CHF c ASCVD</b>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 81</b> , 19, to <b>11/25/81</b> , 19, that (I) (we) last saw the deceased alive on <b>11/24/81</b> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <b>Patrick A. Molony</b>		22c. DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <b>11/25/81</b>								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Patrick A. Molony</b>		22f. ADDRESS <b>Chestertown, Md.</b>												
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>11/28/81</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Church Hill</b>			23d. LOCATION CITY OR TOWN <b>Church Hill, Md.</b>		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME <b>J. Willis Wells</b>		ADDRESS <b>Chestertown, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 2 1981 21</b>		25b. REGISTRAR'S SIGNATURE <b>D. J. McRae</b>								

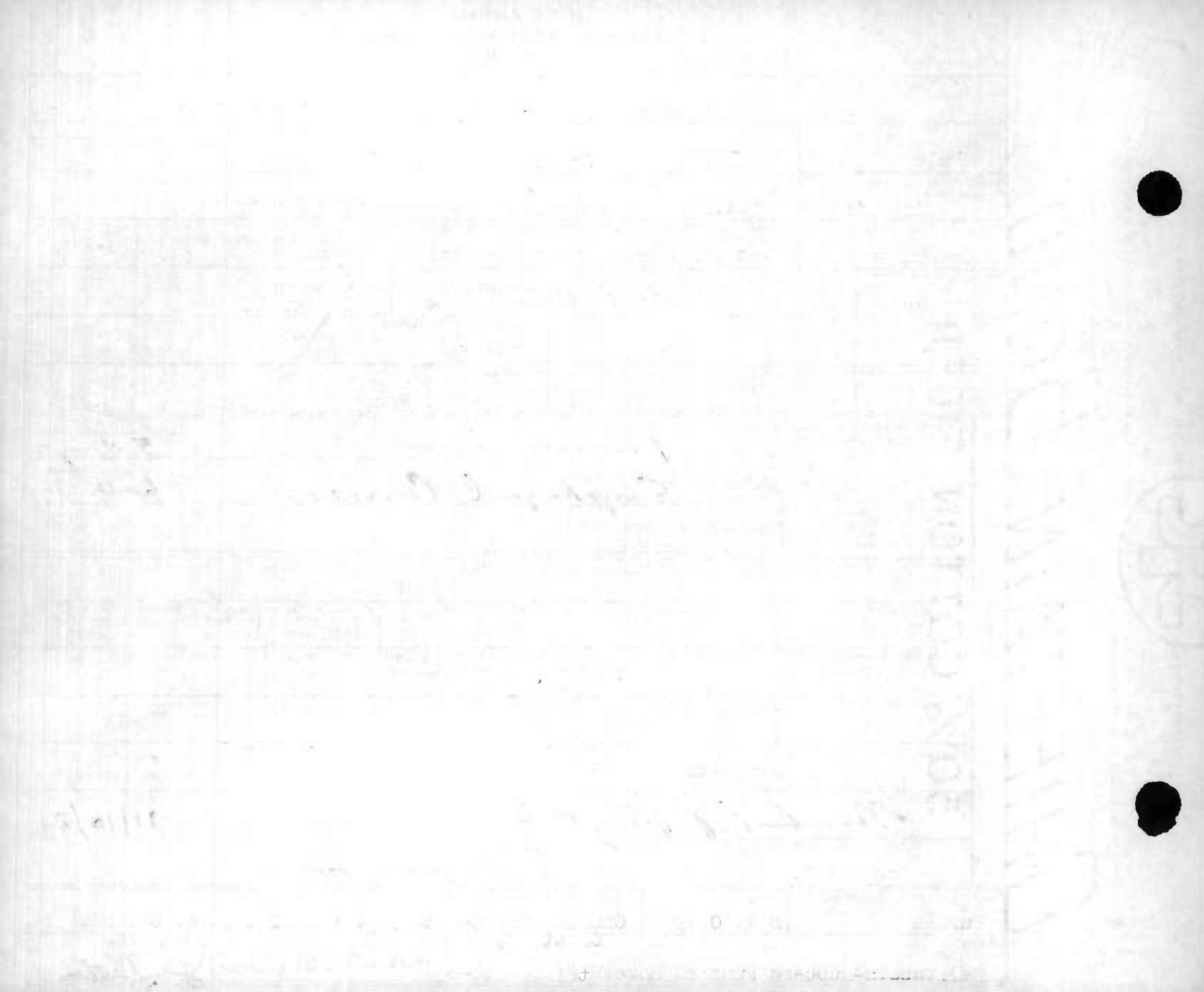


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 81 29587			
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR November 7, 1981							2b. HOUR 4:00 P.M.			
1. DECEASED NAME FIRST MIDDLE LAST Vaudie Lester Puckett, Sr.													
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 31, 1909			6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN				
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent County		12b. KIND OF BUSINESS OR INDUSTRY Saw Mill				
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sawyer			
13a. STATE Maryland			13b. COUNTY Queen Anne's Church Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS RR Box 116					
14. FATHER'S NAME FIRST MIDDLE LAST Milan NMN Puckett			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Jane Webb										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-12-1035		17. INFORMANT Hospital Records, Chestertown, Maryland			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1509 Phleumonia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Esophagel Cancer.										6mth - 1yr.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from November 1, 1981, to November 7, 1981, that (I) (we) last saw the deceased alive on November 7, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE Michael P. Bey M.D.	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11/10/81
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael P. Bey			22e. ADDRESS Chestertown, Maryland										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 10, 1981		23c. NAME OF CEMETERY OR CREMATORIUM Church Hill Cemetery			23d. LOCATION CITY OR TOWN Church Hill, Q.A. Co. Md. COUNTY STATE					
24. FUNERAL DIRECTOR NAME Helfenbein-Hubbard Funeral Home, Rt#1 Box 66-B			25a. DATE REC'D. BY REGISTRAR NOV 16 1981							25b. REGISTRAR'S SIGNATURE Frances Jean Hartman			

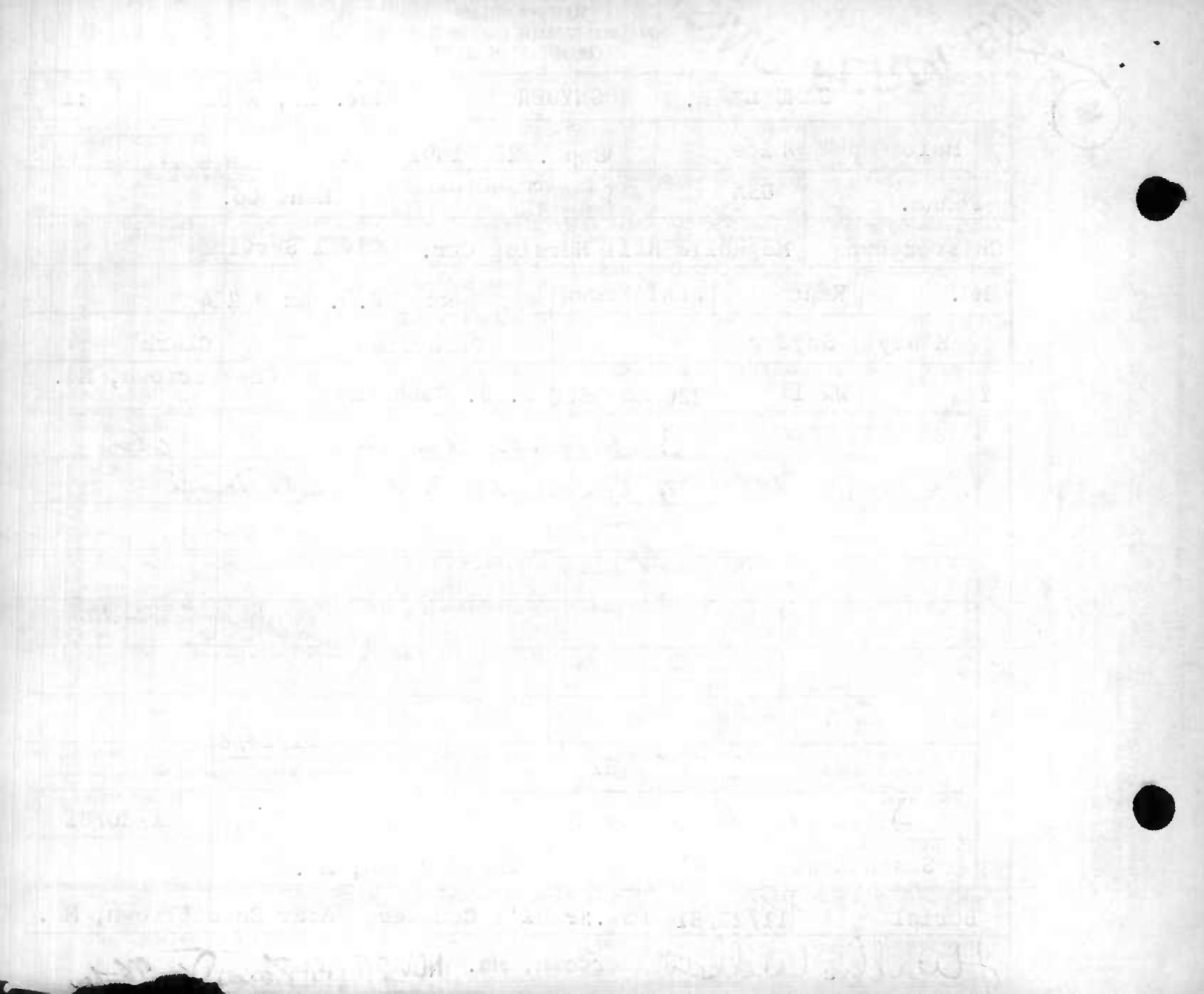


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	29	5	8	0			
										REG. NO.							
1 - FOR STATE REGISTRAR			FIRST <b>SAMUEL A.</b>			MIDDLE LAST <b>SNYDER</b>			7a DATE OF DEATH <b>Nov. 19, 1981</b>		MONTH NOV	DAY 19	YEAR 1981	7b HOUR <b>7:15 P.M.</b>			
3 SEX <b>Male</b>			4 RACE <b>white</b>			5. DATE OF BIRTH <b>Sept. 22, 1891</b>			6 AGE (IN YEARS LAST BIRTHDAY) <b>90</b>		IF UNDER 1 YEAR MONTHS <b>YRS.</b>		# UNDER 24 HRS HOURS <b>MIN.</b>				
7e BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>			7b CITIZEN OF WHAT COUNTRY? <b>USA</b>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>Kent Co.</b>				MD.				
10 CITY OR TOWN OF DEATH <b>Chestertown</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Magnolia Hall Nursing Ctr.</b>			12a USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Civil Service</b>			12b KIND OF BUSINESS OR INDUSTRY								
13a STATE <b>Md.</b>			13b COUNTY <b>Kent</b>			13c CITY OR TOWN <b>Chestertown</b>			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>P.O. Bx # 224</b>						
14 FATHER'S NAME <b>Henry Snyder</b>			15. MOTHER'S MAIDEN NAME <b>Catherine Clark</b>														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b SOCIAL SECURITY NO. <b>WW I 220 44 3600</b>			17 INFORMANT <b>E. S. Cookerly</b>			ADDRESS <b>Chestertown, Md.</b>								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>							
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Arteriosclerotic Cardiovascular Disease</i> (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										11/19/81							
22b. SIGNATURE <i>Susan K. Ross, M.D.</i>										22c. DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Susan Ross</b>										22e. DATE SIGNED <b>11/20/81</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11/23/81</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Paul's Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>near Chestertown, Md.</b>								
24. FUNERAL DIRECTOR NAME <i>J. Willis Well</i>			ADDRESS <b>Chestertown, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1981</b>			25b. REGISTRAR'S SIGNATURE <i>James J. White</i>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

page 3  
should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death.TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8   29589				
										REG. NO.				
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR				
1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	Novembe 30, 1981 3:15 A.M.								
3 SEX female			4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kent			7b CITIZEN OF WHAT COUNTRY? USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8 BALTIMORE CITY OR COUNTY OF DEATH Kent MD.					
10 CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Magnolia Hall Nursing Center			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) domestic			12b. KIND OF BUSINESS OR INDUSTRY					
13a STATE Maryland			13b COUNTY Kent			13c. CITY OR TOWN Rock Hall			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS South Main St.		
14 FATHER'S NAME Joseph Sutton						15. MOTHER'S MAIDEN NAME Martha Cosden								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO. 217 30 8655			17 INFORMANT Frank Shriley - Rock Hall, Md.			ADDRESS					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4392 arteriosclerotic cardiovascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(b) <i>advanced age</i>														
{ DUE TO, OR AS A CONSEQUENCE OF (c) <i>congestive heart failure -</i>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a I certify that (I) <i>the deceased</i> attended the deceased from saw the deceased alive on <i>10-28 1981</i> , and shot in (my) <i>opinion</i> death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did <input type="checkbox"/> did not view the body after death.													22c. DATE SIGNED 11/30/81	
22b. SIGNATURE <i>Harry P Ross MD</i>			22c. DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22d. ADDRESS Ross			22e. ADDRESS Chestertown, Md.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 2 1981			23c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery			23d. LOCATION CITY OR TOWN Chestertown, Md.			COUNTY STATE		
24 FUNERAL DIRECTOR NAME <i>Willie Wells</i>						25a. DATE REC'D. BY REGISTRAR DEC 3 1981			25b. REGISTRAR'S SIGNATURE <i>Pearce Jean Martin</i>					

✓  
- 18 miles SE  
- 18 miles SW  
- 18 miles NE

18 miles SW -  
(in West) I went  
to town

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 29590							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- MATED			MONTH DAY YEAR			2b. HOUR A.M./P.M.	
ARLINGTON			WILKINS			WATKINS						<input type="checkbox"/> 11/21 1981			81			5:00 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR A.M./P.M.	
male		white		6/14/1905		76 yrs.						11/21/81			19			11:00 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
Maryland			USA						Kent										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Rock Hall			at home Rock Hall Ave.									Steelworker							
13a. STATE Md.			13b. COUNTY Kent			13c. CITY OR TOWN Rock Hall			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Rock Hall Ave.							
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST				
Harry			Watkins						Daisy			Wilkins							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			16c. INFORMANT ADDRESS													
no			216 14 2654			Howard Leaverton Chestertown, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <i>Ascvos</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Diabetes mellitus</i>																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?							
												<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															TITLE (SPECIFY) <i>Robert W. Farr</i>				
ACTUAL SIGNATURE			EXAMINER'S NAME (TYPE OR PRINT)			M.D.			MEDICAL EXAMINER			DATE SIGNED							
Robert W. Farr Kent County												11/21/81							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 11/24/81			23c. NAME OF CEMETERY OR CREMATORIAL Silverbrook Crematory			23d. LOCATION CITY OR TOWN Wilmington, Del.			COUNTY STATE							
Cremation																			
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE										
Willis Wells			Chestertown, Md.			NOV 27 1981			James J. Nathan										

